

AUTHORIZATION TO CONSENT TO TREATMENT OF UNEMANCIPATED MINOR

I (We), the undersigned, parent(s) or guardians(s) of _____, a minor, (DOB
_____) do hereby authorize:

Name: _____

Address: _____

Phone: _____

as agent for the undersigned to consent to medial, dental, emergency health and surgical care or treatment, including diagnostic tests, x-ray examination, anesthetic, and hospital care, which is deemed advisably by, and is to be rendered under the general or special supervision of physician, whether such diagnosis or treatment is rendered at the office of said physician or at a health care facility.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but it is given to provide said physician with authority and power to give specific consent to any and all such medical, dental, emergency health and surgical care or treatment which said physician in the exercise of his or her best judgment may deem advisable.

This authorization expires nine (9) months after today's date: _____.

Father

Mother

Legal Guardian (if applicable)

Witness